2005 White House Conference on Aging
Post-Event Summary Report

Name of Event: White House Conference on Aging Mini-Conference on Nutrition
Date of Event: Wednesday, June 29, 2005
Location of Event: Hotel Washington, Washington, DC
Number of Persons Attending: 250
Sponsoring Organizations: National Association of Nutrition and Aging Services Programs; American Dietetic Association; National Resource Center on Nutrition, Physical Activity and Aging; Meals on Wheels Association of America; National Council on the Aging; American Society for Clinical Nutrition; National Association of Area Agencies on Aging; Society for Nutrition Education; National Association of State Units on Aging; Association of Nutrition Services Agencies; Consultant Dietitians in Health Care Facilities; Gerontological Nutritionists; Tufts University Jean Mayer USDA Human Nutrition Research Center on Aging
Contact Name: Emily Ross **Phone Number:** (410)672-5823 **Email:** eross@matzblancato.com

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Priority Issue #1:
Evaluating the cost effectiveness of the Older Americans Act Nutrition Programs.

Specific Issue: Evaluation of the cost effectiveness of the Older Americans Act Nutrition Program in terms of its roles today in health promotion, nutrition risk reduction, chronic disease management, reduction of hospitalizations, lengths of stay, and re-hospitalizations, delay of nursing home placements, and overall prevention of morbidity and mortality.

Barriers/Background & Rationale:

1. Older adults have a right to a healthful diet, with access to a broad array of appropriate, culturally sensitive food and nutrition services. Not all older adults in our country have been afforded this right.
    a. Only 9% of poor older adults' diets are categorized as good based on the USDA Healthy Eating Index.[1]
    b. Malnutrition in older adults is estimated at 20-60% in home care and at 40-85% in nursing homes.[2]
    c. About 40% of community-residing persons 65 years and older have inadequate nutrient intakes.[3]
    d. There is a close connection between inadequate income and hunger. Estimates of food insecurity and hunger in community residing older adults range from 6-16%.[4]
        i. Definitions:[5]
            1. *Food insecurity* exists when the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in a socially acceptable ways is limited or uncertain.
            2. *Hunger* is the uneasy or painful sensation caused by a lack of food. It is a potential consequence of food insecurity.
            3. *Poverty threshold* is $9,060 for a single individual over age 65 and $11,418 for two-person householders over age 65.[6]
    e. Especially vulnerable to food insecurity and hunger are the 24% of older women and 14% of older men who live below 135% of poverty,[7] as well as the 21% of older women and 16% of older men who live alone. Women, those over age 75, and minorities are the most likely to live in poverty and alone.
2. Diet quality plays a major role in preventing, delaying onset and managing chronic diseases.[8] Both the number of older adults and cost of health care are increasing.
    a. Increasing health costs are related to chronic diseases in which nutrition interventions have been proven effective. About 87% of older Americans either have diabetes, hypertension, dyslipidemia or a combination of these chronic diseases. These costly conditions can be ameliorated with appropriate nutrition interventions.

3. The Older Americans Nutrition Program, in existence for 35 years, has not been comprehensively evaluated by the Food and Nutrition Board (FNB) in relation to nutrition and health, quality of life, and independence. Since there were very few nutrition questions in recent national outcome studies, the cost effectiveness of the food and nutrition services may be underestimated.[9] However, the cost of one day in a hospital equals the cost of one year of Nutrition Program meals, based on 2003 reported total expenditures and number of home-delivered meals provided by States.[10]
    a. Other federal food and nutrition assistance programs have been regularly evaluated and re-evaluated in whole and/or in part by the FNB.
        i. Since 2000, 7 reports were published on the USDA Special Supplemental Food Program for Women, Infants and Children, commonly called WIC. The most recent is *WIC Food Packages: Time for a Change.*[11] Both WIC and OAA Nutrition Program began in the early 1970s and serve similar purposes. Yet, WIC currently receives over 5 times more funding through Congressional appropriations than the OAA Nutrition Program. Other FNB studies underway or recently completed include Food Marketing and Diets of Children and Youth, Assessing Worksite Wellness Program Needs, Preventing Childhood Obesity—Health in the Balance. FNB is now evaluating the National School Food Program.
        ii. The FNB at the Institute of Medicine, the National Academies[12] produces widely disseminated reports that provide government, industry, academia, and the public with the best available information and recommendations about food safety, food security, and nutrition, thereby promoting public health and preventing diet-related diseases. Studies have served as the basis for national policy by being thorough, balanced, and objective. National policy makers need advice on nutrition and food science in relation to health to ensure that decisions are supported by the best scientific analysis.
    b. By 2030, the number of older adults will exceed the number of school-age children in 10 states—FL, PA, VT, WY, ND, DE, NM, MT, MA, WV. Five years ago, no state had more people 65+ than those under 18. Twenty-six states will double their 65+ population by 2030, when the oldest Baby Boomers enter their 80s. Growth in the 65+ population will equal 3.5 times the US growth as a whole. This demographic shift has enormous economic and political implications. Competition will increase between our oldest and youngest citizens for tax dollars.[13]

References: **See endnotes.**

Proposed Solution: The Food and Nutrition Board at The National Academies should conduct an evidence-based study of the cost effectiveness of the Older Americans Act Nutrition Program.

Priority Issue #2: Nutrition and Physical Activity Resource Center

Specific Issue: Resource Center(s) for Nutrition and Physical Activity through the Older Americans Act

Barriers/Background & Rationale:

1. Older adults are at great risk of malnutrition and sedentariness.[14] Diet quality and physical activity play major roles in preventing, delaying onset and managing chronic diseases.[15,16] About 87% of older Americans either have diabetes, hypertension, dyslipidemia or a combination of these chronic diseases. These costly conditions can be ameliorated with appropriate nutrition interventions and more active lifestyles.
    a. Both the number of older adults and the cost of health care are increasing. Increasing health costs are related to chronic diseases in which nutrition and physical activity play definite preventive roles.[14-16]
    b. The new national focus on healthy lifestyles was prompted by the American obesity epidemic along with rising health care costs. *HealthierUS* includes nutritious diets and physical activity as strategies for health promotion and disease prevention.[17]

2. The Older Americans Act (OAA) Nutrition Program is the largest program administered by the US Administration on Aging. Yet, there is no requirement for the Assistant Secretary to fund a Resource Center for Nutrition and Physical Activity.
    a. The OAA Nutrition Program is important in health promotion and disease prevention. It is cost-effective. One day in a hospital equals the cost of one year of Nutrition Program meals, based on 2003 reported total expenditures and number of home-delivered meals provided by States.[18] In 2005, OAA Nutrition Program allocations for Title III C-1 (congregate meals), C-2 (home-delivered meals), and Nutrition Services Incentive Program were $718,483,690 or **46%** of total agency funding.
    b. Funding a Resource Center for Nutrition and Physical Activity is at the discretion of the Assistant Secretary for Aging. The current Assistant Secretary for Aging issued a competitive Request for Proposals for a National Resource Center on Nutrition, Physical Activity and Aging in 2003. Florida International University was awarded a 3-year grant ending in FY06. Previously it was funded via Congressional earmarks.
    c. The Older Americans Act[19] requires the Assistant Secretary for Aging to make grants or contracts for three Resource Centers at modest cost. OAA designated Resource Centers focus on Native Americans (Section 418), legal assistance (Section 420), and ombudsman (Section 421). Each Resource Center relates to a relatively small program area and only **1.5-3%** of total agency funding.
3. The multi-facets of food and nutrition services for older adults range from food safety, foodservice operations, nutrition assessment and care planning, culturally appropriate menus and special diets, outcome-oriented nutrition education, counseling, and other services.[20] Designing and promoting physical activity for older adults likewise has many facets. A Resource Center or Centers would focus on different aspects of nutrition and physical activity for older adults. More than one Resource Center should be mandated to capitalize on nutrition and physical activity for health promotion and disease prevention.
4. The lack of a food and nutrition infrastructure for the largest federally funded nutrition assistance program for older adults is in direct contrast to all USDA federal nutrition programs.[21] The Aging Network needs technical assistance, access to the latest scientific information, guidance to establish outcome-based model programs, and help to implement newly released federal guidelines, such as the Dietary Reference Intakes (DRIs) and *Dietary Guidelines for Americans*, as well as national physical activity recommendations targeted to older adults. A Resource Center or Centers can assure that the Aging Network technical assistance needs are met. Another goal is to promote better cooperation between the food industry and the OAA Nutrition Program. Development and/or reformulation of more nutritious food products would expand menus options, food quality, and cost-effectiveness.

Thus, the recommended language for a new section in the Older Americans Act is:

***(NEW)* Sec xxx. RESOURCE CENTERS ON NUTRITION AND PHYSICAL ACTIVITY.**

(a) ESTABLISHMENT-

(1) IN GENERAL - The Assistant Secretary shall make grants or enter into contracts with eligible entities to establish and operate one or more Resource Center(s) on Nutrition and Physical Activity (referred to in this section as "Resource Centers"), targeted to older Americans. The Assistant Secretary shall make such grant(s) or enter into such contract(s) for periods of not less than 3 years.

(2) FUNCTIONS -

A. IN GENERAL - Each Resource Center that receives funds under this section shall-

i. Gather and disseminate information on nutrition and physical activity;

ii. Perform research and disseminate findings and best practices; and,

iii. Provide technical assistance and training to entities that provide services to older adults.

B. AREAS OF CONCERN - In conducting the functions of subparagraph A, the Resource Center(s) shall focus on priority areas of concern of older Americans which shall be-

i. Health promotion and disease prevention through nutrition and physical activity;

ii. Home and community-based services to help rebalance long term care and reduce Medicare and Medicaid costs;

iii. Special population needs, including persons with obesity, diabetes, heart disease, osteoporosis, minorities, ethnicities, and any other populations determined by the Assistant Secretary.

iv. Food safety, food insecurity and food service operations; and,

v. Other problems or issues the Assistant Secretary determines are of particular importance to older individuals.

(3) PREFERENCE - In awarding grants and entering into contracts under paragraph (1), the Assistant Secretary shall give preference to institutions of higher education that have conducted research on, and assessments of, the nutrition and physical activity characteristics and needs of older Americans, and those that have the expertise of registered dietitians. Preference will be given to those institutions of higher education serving minorities

(4) CONSULTATION - In determining the type of information to be sought from, and activities to be performed by the Resource Center(s), the Assistant Secretary shall consult with national organizations, such as the American Dietetic Association, Society for Nutrition Education, American Society for Nutrition, that have expertise in nutrition.

(5) ELIGIBLE ENTITIES - To be eligible to receive a grant or enter into a contract under paragraph (1), an entity shall be an institute of higher education with experience conducting research and assessment on the nutrition and physical activity needs of older individuals.

References: **See endnotes.**

Proposed Solution: The Older Americans Act shall specify one or more Nutrition and Physical Activity Resource Centers.

Priority Issue #3:
Integration of food and nutrition into Medicaid and other state and local Home and Community Based Services.

Specific Issue: Integration of food and nutrition into Medicaid and other state and local Home and Community Based Services as cost effective core services using new federal funds as incentives that allow state flexibility**.**

Barriers/Background & Rationale:

1. Food and nutrition services are essential to keeping Medicaid and Medicare recipients healthy, independent, out of nursing homes and living in the community.[22] Dual Medicare-Medicaid eligibles constitute over 42% of all state Medicaid funding.
2. Medicaid reform in states is attempting to contain the soaring costs of this state-federal healthcare program for the poor. Medicaid spending increased from 8% in 1985 to 20% in 2003, making it the single largest item in state budgets.[23] Medicaid is the budget-busting program in many states today.
3. Current federal Medicaid guidelines are broad. They should be modified to include national requirements that ensure access to fundamental food and nutrition services in Home and Community Based Services (HCBS)[24] and provide federal funds as incentives while preserving state flexibility.
4. Some States provide food and nutrition in HCBS. State cost cutting, especially in Medicaid, threatens the provision of or expansion of these services despite their fundamental nature.[25]
    a. AK, IA, MD, OR and other states provide home delivered meals. IA and MD provide medical nutrition therapy (nutrition care planning, nutrition assessment and dietetic instruction) and FL provides home delivered meals, dietitian services, nutrition assessment and nutrition risk reduction.
5. The US Administration on Aging administers the largest federal nutrition assistance program for older adults, the Older Americans Act (OAA) Nutrition Program. The home-delivered component is commonly called *meals-on-wheels.* The Administration on Aging has a strategic goal of helping older adults access an integrated array of health and social support.[26]
    a. The OAA Nutrition Program provides on average 5 meals a week to homebound older adults.[27] In FY 2003, about 143 million home delivered meals were served to 1 million home bound. Over 40% of the Nutrition Programs reported waiting lists for home delivered meals.[28]
    b. Many older adults who qualify as “nursing home appropriate” under Medicaid Waivers have one or more nutrition-related chronic diseases and functional limitations. These often inhibit the ability to grocery shop, store, prepare, and/or independently eat nutritious safe meals.
    c. The OAA Nutrition Program should be expanded where possible. Five meals a week is inadequate for many home-bound older adults. Yet, the cost of one day in a hospital equals the cost of one year of Nutrition Program meals, based on 2003 reported total expenditures and number of home-delivered meals provided by States.[29]

6. States are moving away from the bias of paying for nursing home care by creating community-based options.[30] It is essential that food and nutrition services become part of comprehensive care in HCBS. Criteria should be established to determine the number of meals, snacks, supplements, and nutrition support that each eligible individual requires. A nutrition monitoring mechanism should be established as part of HCBS, so that the common, devastating nutritional problems (weight loss, dehydration, pressure ulcers) often seen upon admission to nursing homes and other institutional settings do not become widespread among the frail homebound in community settings.
7. A national monitoring system that uses existing state medical assistance data should be established to ensure that older adults, especially the homebound and those who live alone, have access to not only health care, but to adequate safe food and nutrition services.[31] The monitoring system could be modeled on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services that began collecting state data in 1990 under a revision of the Social Security Act. EPSDT monitors the health care of Medicaid-eligible children.
    a. EPSDT is a comprehensive and preventive child health program for Medicaid beneficiaries under age 21. Defined by federal law in 1989, it consists of two mutually supportive, operational components[32]:
        i. Assuring the availability and accessibility of required health care resources, and
        ii. Helping Medicaid recipients and their parents or guardians effectively use these resources.

Thus, Medicaid reform shall emphasize the fundamental nature of food and nutrition services given their essential role in health promotion, disease prevention, risk reduction, and disease management. These services are essential to maximizing independence and quality of life, and will thereby reduce Medicaid and Medicare expenditures. EPSDT can be the model for establishing a monitoring system for our aging population. The Medicaid Commission recently enacted by HHS Secretary Leavitt shall consider the cost effectiveness and preventive nature of food and nutrition programs.

References: See endnotes.

Proposed Solution: Medicaid and other state and local Home and Community Based Services shall integrate food and nutrition as cost effective core services using new federal funds as incentives that allow state flexibility.[33]

RESOLUTION #1

[1] Federal Interagency Forum on Aging Related Statistics. *Older Americans 2004: Key Indicators of Well Being*. Washington, DC: US Government Printing Office, Nov 2004.

[2] Nutrition Screening Initiative. Nutrition statement of principle. 2002. American Dietetic Association, American Academy of Family Physicians. Available at: www.eatright.org/Public/Files/nutrition(1).pdf

[3] Institute of Medicine, Committee on Nutrition Services for Medicare Beneficiaries. *The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population*. Washington, DC: National Academy Press; 2000.

[4] Food Security Institute, Center on Hunger and Poverty. Hunger and food insecurity among the elderly. Hunger Issue Brief, Feb 2003. Brandeis University. Available at: www.centeronhunger.org

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[6] US Census Bureau. Poverty Thresholds 2004. Available at: www.census.gov/hhes/poverty/threshld/thresh04.html

[7] US Census Bureau. POV01. Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race, 2004. Available at: pubdb3.census.gov/macro/032004/pov/toc.htm

[8] US Department of Health and Human Services. *Healthy People 2010*. 2nd ed. Vol.1. Washington, DC: US Government Printing Office. 2000.

[9] Performance Outcome Measures Project (POMP) 4, Highlights from the *Pilot Study: First National Survey of Older, Americans Act Title III Service Recipients* – Paper No. 2. Available at: www.gpra.net

[10] US Administration on Aging. 2003 State Program Report. Available at: www.aoa.gov/prof/agingnet/NAPIS/SPR/2003SPR/profiles/2003profiles.asp

[11] Institute of Medicine, Committee to Review the WIC Food Packages. *WIC Food Packages: Time for a Change*. Washington, DC: National Academy Press; 2005.

[12] Food and Nutrition Board, National Academies of Sciences. Available at: www.iom.edu/board.asp?id=3788

[13] US Census Bureau. Available at: www.census.gov/population/www/projections/popproj.html .

RESOLUTION #2

[14] Federal Interagency Forum on Aging Related Statistics. *Older Americans 2004: Key Indicators of Well Being*. Washington, DC: US Government Printing Office, Nov 2004.

[15] Institute of Medicine, Committee on Nutrition Services for Medicare Beneficiaries. *The Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population*. Washington, DC: Nat'l Academy Press; 2000.

[16] US Dept Health & Human Services. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: CDC, National Center for Chronic Disease Prevention & Health Promotion, 1996. Available at: www.cdc.gov/nccdphp/sgr/sgr.htm

[17] *HealthierUS*. Available at: http://healthierus.gov/index.html .

[18] US Administration on Aging. 2003 State Program Report. Available at: www.aoa.gov/prof/agingnet/NAPIS/SPR/2003SPR/profiles/2003profiles.asp

[19] Older Americans Act. www.aoa.gov/about/legbudg/oaa/legbudg_oaa.asp

[20] Finelli-Kuczmarski M, Weddle DO. American Dietetic Association Position Statement: Nutrition across the spectrum of aging. *J Am Diet Assoc.* 2005;105:616-33.

[21] US Dept of Agriculture, Food and Nutrition Services. Available at: www.usda.fns.gov

RESOLUTION #3

[22] Institute of Medicine Committee on Nutrition Services for Medicare Beneficiaries. *Role of Nutrition in Maintaining Health in the Nation's Elderly: Evaluating Coverage of Nutrition Services for the Medicare Population*. Washington, DC: National Academy Press; 2000.

[23] National Governors Association. *Medicaid in 2005: Principles and Proposals for Reform*. Feb 2005. Available at: www.nga.org .

[24] Home and Community-Based 1915 (c) Waivers. Centers for Medicare & Medicaid Services. Available at: cms.hhs.gov/medicaid/1915c/default.asp.

[25] Overview of State Home and Community-based Services (HCBS) Waivers**.** Centers for Medicare and Medicaid. Available at: www.cms.hhs.gov/medicaid/1915c/agedphysdis.pdf.

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[32] Medicaid and EPSDT. Centers for Medicare and Medicaid. Available at: www.cms.hhs.gov/medicaid/epsdt/default.asp.

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